UNITED
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Secretariat

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22 December 1994

INFORMATION CIRCULAR

To: Members of the staff at duty stations away from Headquarters

From: The Controller

Subject: VAN BREDA MEDICAL, HOSPITAL AND DENTAL INSURANCE*

1. The purpose of the present circular is to set out the provisions concerning renewal of the Van Breda medical, hospital and dental insurance plan for staff members at offices away from Headquarters, which will take effect on 1 January 1995. The key features of the renewal for 1995 are:

(a) Premiums will remain the same as in 1994;

(b) The annual benefit maximum is increased from $200,000 to $250,000;

(c) All other provisions of the plan will be the same as in 1994;

(d) A modification of the conversion privilege enabling the spouse of a staff member who ceases to be covered as a result of divorce to apply for medical coverage with Van Breda (see para. 9).

2. By comparison with the performance of the plan in 1993, when a deficit was incurred, in 1994 the plan incurred a modest surplus. Accordingly, it has been possible to renew the plan with no change in premium levels. In addition, the percentages of medical net salary which determine the monthly contribution amounts payable by staff members have been slightly reduced in line with the overall 50:50 cost-sharing relationship between the Organization and participants.

3. In reflection of world-wide increases in medical, hospital and dental treatment costs, the annual maximum is increased from $200,000 to $250,000 per insured participant effective 1 January 1995.

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* Personnel Manual index No. 6190.

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4. The schedule of premiums which will become effective on 1 January 1995, as well as the related staff contribution rates, are set out in the tables below:

Premium levels

Type of coverage	Monthly premiums (United States dollars) Current	Effective 1 January 1995
Staff member only	85.00	85.00
Staff member and one family member	179.00	179.00
Staff member and two or more eligible family members	296.00	296.00

Staff contributions

Type of coverage	Percentages of medical net salary Current	Effective 1 January 1995
Staff member only	1.36	1.29
Staff member and one family member	2.20	2.09
Staff member and two or more eligible family members	3.49	3.32

5. In line with the methodology used in the calculation of staff contributions towards premiums for other United Nations insurance schemes, the contributions of participants in the Van Breda scheme are calculated as a percentage of their respective medical net salaries in accordance with the rates set forth above. Medical net salary consists of gross salary, less staff assessment, plus language allowance, non-resident's allowance and post adjustment, as applicable. In no case will staff contributions be greater than 85 per cent of the premiums shown above.

Hospitalization in the United States

6. With effect from 1 January 1992, the "prior approval" requirement pertaining to non-emergency hospitalization in the United States was replaced by an arrangement under which a "cap" of US$ 700 applied to the daily semi-private hospital room rate for hospitalization in the United States. The US$ 700 cap will be maintained in 1995. Details concerning the application of the current

US$ 700 limit on hospitalization in the United States are set out in annex II to the present circular.

Second surgical opinion

7. As announced in ST/IC/1991/73, a second surgical opinion in connection with 16 surgical procedures ceased to be required with effect from 1 January 1992. This meant that Van Breda would no longer implement a reimbursement penalty for failure to obtain a second surgical opinion in connection with these procedures. This provision is maintained in the 1995 renewal. However, participants continue to be strongly encouraged to seek a second surgical opinion whenever possible from a qualified independent physician. Thus, while a second surgical opinion is no longer a requirement, Van Breda will continue to reimburse at the rate of 100 per cent expenses incurred in obtaining second opinions regarding any of the 16 procedures listed in annex III to the present circular.

Basis for claim reimbursement in United States dollars

8. Claim reimbursement is made in United States dollars, converted from the currency in which the hospital, medical or dental expenses have been incurred. Reimbursement in United States dollars is based on the United Nations operational rate of exchange in effect on the date the medical and dental expenses are incurred and, in the case of hospital expenses, on the date the hospital bill is rendered.

Conversion privilege

9. Participants who cease employment with the United Nations and who do not qualify for after-service health insurance benefits may arrange for medical coverage with Van Breda under an individual contract, provided that application is made within 31 days of termination of coverage under the United Nations group policy. The conversion privilege, which is part of the United Nations group contract with Van Breda, means that the insurer cannot refuse to insure an applicant and that no certification of medical eligibility is required. The conversion privilege, however, does not mean that the same insurance premium rates or schedule of benefits in effect for the United Nations group policy will be offered in respect of individual insurance contracts. Participants should bear in mind, however, that under the conversion privilege, dependants may only apply for individual coverage at the same time as the staff member, upon cessation of employment with the United Nations. EFFECTIVE 1 JANUARY 1995, the spouse of a staff member whose eligibility for coverage under the United Nations group plan ceases as a result of divorce occurring on or after this date is eligible to apply for medical coverage with Van Breda under the above arrangements, so long as application is made within 31 days of termination of coverage under the United Nations group policy.

10. Details concerning conversion to an individual insurance policy may be obtained by communicating directly with Van Breda at the following address:

J. Van Breda and Co. International
Plantin en Moretuslei 295
B-2140 Borgerhout
Antwerp, Belgium

Telex No.: BREDCO B 31788
Fax No.: 00 323 271 02 47 (facsimile transmission)
Telephone No.: 00 323 217 5111

Eligibility for enrolment in the Van Breda plan

11. Except for staff members whose duty station is New York, Geneva or Vienna and locally recruited staff members at duty stations where the Medical Insurance Plan (MIP) is established, all staff members holding appointments of three months or longer under the 100 Series of the Staff Rules or one month or longer under the 200 Series of the Staff Rules may enrol themselves and eligible family members in the United Nations Van Breda plan. Staff members holding appointments of limited duration (LD) under the 300 Series of the Staff Rules, except those who receive a fixed monthly cash amount towards the cost of health insurance, are also eligible to enrol in the Van Breda plan in line with the relevant provisions of administrative instruction ST/AI/395, dated 2 June 1994.

12. Enrolment in the Van Breda plan at the time of initial appointment must be accomplished within 31 days of the date of entry on duty (EOD). For enrolment purposes, applicants will be required to present proof of eligibility from their respective personnel or administrative officers attesting to their current contractual status. The enrolment of eligible family members requires the provision of evidence of the status of such family members. In most instances, the necessary proof of eligibility will be contained in the personnel action form.

Eligible family members for insurance purposes

13. "Eligible family members" refers to a spouse and one or more eligible children. A spouse is always eligible. A child is eligible to be covered under this scheme until the end of the calendar year in which he or she attains the age of 25, provided that he or she is not married and not in full-time employment; disabled children may be eligible for continued coverage after age 25. Complete information regarding these provisions can be found in information circular ST/IC/86/72, entitled "Age limitation on the participation of dependent children in United Nations health insurance schemes".

Enrolment at times other than upon entry on duty

14. Staff members appointed under the 100 Series of the Staff Rules who have not enrolled themselves and eligible family members within 31 days of the date of their entry on duty (EOD) have an opportunity one time each year to do so. The annual enrolment period generally is set for the first week of June, the specific dates being announced each year sufficiently in advance of the

occasion. The effective date of insurance coverage which is applied for during the annual enrolment week is the first day of the following month.

15. Staff members appointed under the 200 Series of the Staff Rules (project personnel) are, under staff rule 206.4 (a), required to participate in a medical insurance scheme provided by the United Nations unless exemption from such participation is expressly stated in the letter of appointment. Staff Rule 206.4 (b) provides that such personnel, if appointed for a period of one month or more and participating in a medical insurance scheme provided by the United Nations, may enrol their spouses and dependent children in the scheme. Project personnel who have not enrolled their spouses or eligible dependent children in the Van Breda plan at the time of initial appointment have an annual opportunity to do so. In the case of project personnel, the annual enrolment opportunity occurs on the anniversary of their entry on duty and insurance coverage for added dependants will be effective as of that date.

16. Eligible staff members holding appointments of limited duration under the 300 Series of the Staff Rules who have not enrolled themselves in the Van Breda plan at the time of initial appointment because they maintain their own coverage have an annual opportunity to do so. The annual enrolment opportunity occurs on the anniversary of their entry on duty.

17. At times other than the annual enrolment periods referred to in paragraphs 14 to 16 above, staff members (100 or 200 Series) and their eligible family members may be enrolled in the Van Breda plan only if at least one of the following events occurs and application for enrolment is made within 31 days thereafter:

(a) Upon transfer from one duty station to another;

(b) Upon return from Special Leave Without Pay (SLWOP) (see para. 21 below);

(c) Upon assignment to a mission under certain conditions (see para. 22 below);

(d) Upon marriage, birth or legal adoption of child for coverage of the related family member.

18. Staff members who can demonstrate that they were on mission or annual or sick leave during the annual enrolment opportunity period may enrol within 31 days of their return to their duty station.

19. Applications between enrolment opportunity periods based on circumstances other than those listed in paragraph 17 above or not received within 31 days of the event giving rise to eligibility will not be receivable. In this regard, it should be noted that termination of health insurance coverage under a scheme not offered by the United Nations or another organization within the common system will in no case give rise to any right on the part of a staff member or family member to immediate enrolment in a United Nations plan. If such termination occurs between annual enrolment opportunity periods, the staff member must wait until the next annual opportunity to enrol in a United Nations plan. Staff members who for any reason may be uncertain about the continuity of their

outside coverage are urged to consider enrolling in the United Nations scheme during the established annual enrolment period.

Staff transferred to another duty station

20. Staff members who transfer to another duty station but who did not have medical insurance prior to the transfer may enrol themselves and eligible family members in the United Nations health insurance plan upon transfer. The enrolment application must be submitted within 31 days of the date of transfer, and the effective date of coverage will be the transfer date at the new duty station. This provision applies also in the case of transfer to Headquarters, in which case the new enrolment will be in one of the health insurance plans offered at Headquarters. Staff members are reminded that if they transfer from one duty station to another and in the process are transferred from one payroll system to another, they should, upon arrival at the new duty station, ensure that their insurance coverage is recorded in the new payroll system so that the deduction of monthly premium contributions may be continued without a break.

Staff on special leave without pay

21. Staff members who are granted special leave without pay are reminded that they may retain health insurance coverage during such periods or may elect to discontinue such coverage for the period of the special leave:

(a) Insurance coverage maintained during special leave without pay. If the staff member decides to retain coverage during the period of special leave without pay, the Insurance Section (if payrolled at Headquarters) or the relevant administrative office (if payrolled elsewhere) MUST be informed directly in writing by the staff member of his or her intention at least one month in advance of the commencement of the special leave. At that time, the administrative office concerned will require evidence of the approval of the special leave, together with payment covering the full amount of the cost of the coverage retained (both the staff member's contribution as well as the Organization's share, since no subsidy is payable during such leave);

(b) Insurance dropped while on special leave without pay. Should a staff member decide not to retain insurance coverage while on special leave without pay, no action is required upon commencement of the special leave;

(c) Re-enrolment upon return to duty following special leave without pay. Regardless of whether a staff member has decided to retain or drop insurance coverage during a period of special leave without pay, it is essential that he or she re-enrol in the plan within 31 days of return to duty. Failure to do so will mean that the staff member will be unable to resume participation in the insurance plan until the following annual enrolment opportunity period.

Staff members assigned on mission

22. In view of the large number of staff members going on mission assignment, it has been decided to extend a special health insurance enrolment opportunity

to such staff members. The provisions in this respect, which will apply to all staff members going on mission for six months or more, are as follows:

(a) Staff members who at present are not enrolled in the Van Breda plan will be allowed to enrol themselves and eligible family members. The insurance will become effective on the first day of the month in which the mission assignment commences. Enrolment in the plan in these circumstances must be completed prior to the departure of the staff member on mission assignment;

(b) Staff members who elect to enrol in the Van Breda plan in the circumstances set out in (a) above forgo the right to make any further change during the annual enrolment period taking place in the same calendar year as the commencement of the mission assignment. The next opportunity for these staff members to make any change in their insurance coverage will be at the time of the annual enrolment period of the following year;

(c) Staff members going on mission assignment who wish to enrol in the Van Breda plan or change their present coverage, as provided above, must present evidence to the Insurance Section or to their administrative office, as the case may be, of the mission assignment and its duration.

Staff member married to another staff member

23. Staff members are reminded that in the case of a staff member married to another staff member, the insurance coverage, whether at the two-person or family level, must be carried by the higher-salaried staff member. It should also be noted that if one spouse retires from service with the Organization before the other spouse, the spouse who remains in active service must become the subscriber even if the retired spouse had been the subscriber up to the date of retirement and is eligible for after-service health insurance (ASHI) benefits following separation from service.

Staff members with dependants residing in the United States

24. Staff members are reminded that the Van Breda plan is designed to provide medical, hospital and dental coverage for participants stationed outside the United States. Therefore, staff members stationed outside the United States but with eligible dependants residing in the United States may wish to enrol instead in the Aetna hospital/major medical insurance plan. As the Aetna plan does not include dental coverage, participants may also wish to subscribe to the (optional) Group Health Incorporated (GHI) dental plan. While it is not required that staff members with eligible dependants residing in the United States enrol in a Headquarters plan, it should be borne in mind that persons not covered by a United States insurance company may not be admitted to hospital unless expenses are prepaid or guaranteed by Van Breda. The US$ 700 daily hospital room rate limit will also apply (see para. 6 above). In addition, in emergency situations, evidence of coverage by a recognized United States insurance company (in the case of the United Nations, Aetna) is usually required to ensure hospital admission. However, staff members with eligible dependants residing in the United States may switch their coverage to the Headquarters

plan(s) only during the annual enrolment opportunity period, and must present evidence of the United States residency of the eligible dependants concerned.

Cessation of coverage of family members

25. The Insurance Section at Headquarters or the relevant administrative office should be notified immediately in writing of changes in the staff member's family which result in a family member ceasing to be eligible, e.g., a spouse upon divorce or a child reaching the age of 25 years, marrying or taking up full-time employment. Staff members who wish to discontinue coverage of a family member under a United Nations plan for any other reason may do so at any time, although this is strongly discouraged. The responsibility for initiating the resulting change in coverage (e.g. from "staff member and spouse" to "staff member only" or from "family" to "staff member and spouse") rests with the staff member. It is in the interest of staff members to provide this notification promptly whenever changes in coverage occur in order to benefit from any reduction in premium contribution which may result. Any such change will be implemented on the first of the month following receipt of notification. No retroactive adjustments can be made as a result of failure to provide timely notification of any change to the Insurance Section or administrative office.

After-service health insurance

26. Established policy in regard to eligibility to participate in the United Nations after-service health insurance (ASHI) programme, as well as the related administrative procedures, is set out in administrative instruction ST/AI/394, dated 19 May 1994. Staff members are reminded that, among the eligibility requirements for after-service health insurance coverage, they must be enrolled in a United Nations scheme at the time of separation from service. A minimum of 5 years of prior coverage in a United Nations or specialized agency health insurance scheme is necessary to qualify for unsubsidized after-service health insurance participation and 10 years of prior coverage for subsidized participation. In both cases, the staff member must be 55 years of age or over as of the date of separation. It should also be noted that only family members enrolled with the staff member at the time of separation are eligible for continued coverage under the after-service health insurance programme. Former staff members who reside in the United States are reminded that they are ineligible for participation in the Van Breda plan and that they must switch to a Headquarters plan within 31 days of taking up residence in the United States.

Where to address claims and benefit inquiries

27. Although the staff of the Insurance Section is available to assist staff members in administrative matters concerning participation in the Van Breda plan, claims questions should always be taken up in the first instance directly with the insurance company concerned. The address and telephone, telex and fax numbers of Van Breda are provided in paragraph 10 above.

28. Annex I to the present circular contains a summary of the benefits payable under the Van Breda plan.

29. Annex II contains a recapitulation of the provisions pertaining to hospitalization in the United States.

30. Annex III sets out relevant details concerning the second surgical opinion requirement.

Annex I

VAN BREDA INSURANCE SCHEME

1. The Van Breda insurance scheme provides for reimbursement of medical, hospital and dental treatment costs up to a maximum of $250,000 per insured participant per calendar year. In addition to the maximum reimbursement per calendar year, certain maxima per treatment, procedure or service may also be applied on the basis of a determination of reasonable and customary charges for the benefit at the place of treatment.

2. The scheme is subject to the following provisions and limitations:

(a) Under the basic component, reimbursement in respect of medical treatment prescribed by qualified doctors is limited to 80 per cent of the costs incurred, including doctors' fees. Under the major medical component, 80 per cent of the remaining unpaid costs is paid, subject to a co-payment of $200 per participant and $600 per family;

(b) The cost of hospital services (excluding doctors' fees) is reimbursed at the rate of 100 per cent of the costs involved, including such items as bed and board, general nursing service, use of the operating room and equipment, use of the recovery room and equipment, laboratory examinations, X-ray examinations and drugs and medicines for use in the hospital. For hospitalization in Europe and in North America, the standard of accommodation is limited to semi-private room care, i.e., two or more patients in the same room, except that, under the following circumstances, private-room care will be reimbursed in full:

(i) When the nature and gravity of the illness requires private-room care and such care is requested by the attending physician;

(ii) When the patient is admitted on an emergency basis to a hospital that has semi-private accommodation but none is available at the time;

(iii) When the patient is admitted to a hospital that does not have any semi-private accommodation, i.e., it has no standard of accommodation other than private rooms and general wards.

Europe and North America are defined for this purpose as Europe, including Malta, Cyprus and Turkey (European portion), and Canada and the United States of America;

(c) The cost of dental treatment is reimbursable at the rate of 80 per cent up to a maximum sum of $750 per insured participant per calendar year. The cost of dento-facial orthopaedics is covered only if the treatment is started before the patient has reached his or her fifteenth birthday, and reimbursement is provided only during a treatment period of four years;

(d) The cost of out-patient mental health treatment by a psychiatrist is covered, as well as the services of a licensed psychoanalyst, a licensed psychologist or a licensed psychiatric social worker. The cost in respect of insured participants is reimbursable at the rate of 50 per cent and to a maximum

reimbursement of $500 for not more than 50 visits per insured person in any consecutive six-month period;

(e) The cost of treatment for substance (alcohol and/or drug) abuse is covered, under certain conditions. The coverage includes in-patient treatment for detoxification and rehabilitation at a facility certified for such treatment, subject to the prior approval of Van Breda. Such treatment will normally be limited to 30 days in a calendar year. In addition, the plan covers out-patient counselling for the purpose of diagnosis and treatment. The costs of out-patient counselling are reimbursable at the rate of 50 per cent and to a maximum reimbursement of $1,000 for not more than 50 visits per insured person in any consecutive 12-month period. Of these 50 visits, up to 20 may be allocated to counsel covered family members of the participant undergoing treatment for the substance abuse problem;

(f) The cost of radiological treatment is reimbursable at the rate of 80 per cent only if the patient has been referred to the specialist by the doctor in attendance;

(g) The cost of hearing aids and optical lenses is covered, with the following limitations:

(i) Hearing aids. Reimbursement at 80 per cent (only basic coverage, no major medical coverage), with a maximum of $300 per apparatus, including the related examination, and a maximum of one apparatus per ear in any period of three years;

(ii) Optical lenses. Reimbursement at 80 per cent (only basic coverage, no major medical coverage) with a maximum of $30 per lens and a maximum of two lenses in any period of two years.

In order to be entitled to these benefits, a staff member or the participating family member will have to have been a participant in the Van Breda scheme for one year or more;

(h) The cost of two blood tests per year for the HIV virus.

3. The insurance scheme does not cover:

(a) Periodic preventive health examinations;

(b) Examination of the eyes for optical lenses (eyeglasses or contact lenses);

(c) Injuries as a consequence of voluntary or intentional action on the part of the insured participant;

(d) Insured participants who are mobilized or who volunteer for military service in time of war;

(e) Injuries resulting from motor-vehicle racing or dangerous competitions in respect of which betting is allowed (normal sports competitions are covered);

(f) The consequences of insurrections or riots if, by taking part, the insured participant has broken the applicable laws; and the consequences of brawls, except in cases of self-defence;

(g) Spa cures, rejuvenation cures or cosmetic treatment (cosmetic surgery is covered, however, where it is necessary as the result of an accident for which coverage is provided);

(h) The direct or indirect results of explosions, heat release or irradiation produced by transmutation of the atomic nucleus or by radioactivity or resulting from radiation produced by the artificial acceleration of nuclear particles;

(i) Expenses for, or in connection with, travel or transportation, whether by ambulance or otherwise, except that charges for professional ambulance service used to transport the insured participant between the place where he or she is injured by an accident or stricken by disease and the first hospital where treatment is given will not be excluded.

4. In respect of 16 surgical procedures listed in annex III to the present circular, the cost of a second opinion will be reimbursed at 100 per cent and, should a participant desire a third opinion, the cost of that opinion will also be reimbursed at the rate of 100 per cent. No penalty will be assessed in cases in which surgery is performed without the benefit of a second opinion.

5. Subscribers should note that claims for reimbursement must be submitted to Van Breda no later than two years from the date on which the medical expense was incurred. Claims received by Van Breda later than two years after the date on which the expense was incurred will not be eligible for reimbursement.

Annex II

PROVISIONS PERTAINING TO HOSPITALIZATION IN THE UNITED STATES

1. A prior approval measure was introduced on 1 March 1988 to control the frequency of hospitalization within the United States where overall costs frequently run far above the costs for comparable medical services in other countries. With effect from 1 January 1993, the "prior notification" requirement was dropped from the plan.

2. While a participant is free to seek admission to a United States hospital without providing any notification to Van Breda, reimbursement for such hospitalization will continue to be subject to a limit of $700 in respect of the daily semi-private room rate. Thus, if a participant chooses a hospital at which the daily semi-private room rate exceeds $700, the cost of the daily room rate above $700 will be borne entirely by the participant. There will be no change in the reimbursement for other services. In this connection, it should be noted that hospital costs vary considerably throughout the United States, and costs may exceed the $700 reimbursement ceiling, particularly in parts of California, Florida, Massachusetts, New York, Texas and Washington, D.C., where the costs may be much higher in certain hospitals.

3. The $700 limit will not apply to semi-private hospital accommodation in three specific circumstances:

(a) In connection with medical evacuation to any hospital in the United States authorized by the United Nations Medical Director;

(b) In cases of bona fide medical emergency arising while in the United States;

(c) In situations where the necessary medical treatment can only be provided at a hospital where the daily semi-private room rate exceeds $700. To avoid the obligation to meet daily room-rate expenses in excess of $700 in such cases, confirmation must be obtained from Van Breda prior to the hospital admission.

Annex III

SECOND SURGICAL OPINION REQUIREMENT

1. With effect from 1 January 1992, participants were no longer required to obtain a second opinion prior to undergoing surgery. As of that date, no reimbursement penalty has been assessed by Van Breda for failure to provide evidence of a second opinion in connection with any surgery. However, whenever feasible, participants are encouraged to seek a second surgical opinion, particularly for the 16 surgical procedures listed below. For this reason, Van Breda will continue to reimburse at 100 per cent the cost of a second opinion rendered by a qualified physician in connection with these 16 surgical procedures. If the second opinion does not agree with the first, a third opinion may be sought, and will also be fully reimbursed. Please note that the second opinion must be provided by a physician not associated or in practice with the physician who originally recommended or proposed to perform the surgery.

2. The 16 surgical procedures for which second opinions will be reimbursed at the rate of 100 per cent are:

	Procedure	Explanation
1.	Bunionectomy	Removal of bunions
2.	Cholecystectomy	Removal of gall bladder
3.	Dilation and curettage	Dilation of cervix and scraping of uterus
4.	Excision of cataracts	Removal of cataracts
5.	Haemorrhoidectomy	Removal of haemorrhoids
6.	Hernia (inguinal) repair	Repair of hernia in the groin
7.	Hysterectomy	Removal of uterus
8.	Knee surgery	Knee operation
9.	Laminectomy	Removal of part of spine
10.	Mastectomy: partial or complete	Partial or complete removal of breast tissue
11.	Prostatectomy	Removal of prostate
12.	Septo-rhinoplasty	Nose surgery for functional improvement
13.	Spinal fusion	Surgical welding of spine segments

	Procedure	Explanation
14.	Tonsillectomy and/or adenoidectomy	Removal of tonsils and/or adenoids
15.	Varicose veins	Removal and tying of varicose veins
16.	Coronary artery bypass	Heart surgery to bypass one or more blocked arteries feeding the heart

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